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PATIENT INFORMATION FORM

Patient Name: _____
First Middle Last

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Social Security Number: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date: _____ Age: _____ ☐ Male ☐ Female

If patient is a minor, name of responsible party: _____

Responsible Party Occupation: _____ Business Phone: _____

Parent/Guardian SSN: _____ Parent/Guardian Birth Date: _____

Name of Spouse: _____ Spouse Employed by: _____

Family Physician: _____ Address: _____

City: _____ State: _____ Zip: _____

In Case of Emergency, Contact: _____ Phone: _____

Who may we thank for referring you to this office?: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Authorization and Assignment: (Please read and sign below)

I hereby authorize InSight Vision Center Medical Group, Inc. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physicians(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date: _____ **Signature:** _____